CALIFORNIA DEPARTMENT OF Mental Health

2011 COMMUNITY MENTAL HEALTH SUMMER STAKEHOLDER SERIES
DATE: August 12, 2011 LOCATION: Napa, CA

Participants

04	Consumers/Family Members/Consumer Advocates
06	Providers
07	County Representatives
01	Other
12	Phone Participants
30	**Total Participants**

Pre-Meeting Education Session- Questions/Comments

- Is consideration being given to health care reform (i.e., expansion of Medi-Cal population)?
- New opportunities for parity
- What is the potential for lost opportunities?
- How will statewide efforts around person centered treatment planning be affected by the Medi-Cal transfer? Current efforts are more aligned to MHSA.

Background and Context Questions/Comments

- With the reduction of staff, was that funding passed to the local level? Yes
- What kind of influence does this stakeholder process have on actual decisions made? The summary report will include stakeholder input and will be considered by the Legislature and Governor.
- What does CMHPC stand for? CA Mental Health Planning Council
- What is the difference between DMH and CMHPC? DMH = Administrator CMHPC = Oversight Body
- NAMI = National Alliance on Mental Illness. They recently changed the name in order to reduce stigma.
- Federal carve-out of funds: What is the role of these function/programs? Functions still a part of the existing Role of DMH (PATH Grant, etc.) This process will help determine where these functions should be housed. DHCS or (joint ADP and DMH) Department of Behavioral Heath?

Based upon today's presentation, what are the changes in mental health at the state level that stand out for you?

- Great opportunity for a paradigm shift = partnership with local county and clients/family/communities
- Local control of services. State/federal uniformity
- Shifting responsibilities is both an opportunity and risk – local fairness is an issue.
- Local control means less bureaucracy and more efficiency.

Please note: Stakeholder questions appear in black font, DMH response indicated in red font.

- Concern that local stakeholders may not know enough about state level functions to make informed recommendations
- Is there any opportunity to re-evaluate policies and regulations to make programs and funding more adaptable to local level (i.e., requirement of 51% of FSP funds allocated to children/youth)?
- Concern about fairness and "statewideness" – measurement of impact of programs/services statewide, sharing best practices, outcomes
- There is concern about funding distribution
  - AB100 = "State will perform x functions" but who is "the State"
  - There are resources and AB100 helps us to navigate that
- Will Orange Co get more money? There is an existing funding allocation formula, it will not change as a result of this transition process.
- Will State legislators still listen to local stakeholder input without support of state DMH? Yes, there is a commitment to on-going stakeholder input, the MHSOAC and CMHPC also provide this support to stakeholders.
- Shared responsibility – work more closely with local programs and providers not either/or but and (shared functions)
- Older adults are historically un-served in the nation – is that information being considered. Napa = large population of older adults
- Concerned, in this transition that we might lose a statewide voice and advocacy in Administration. Maintain a strong statewide voice in light of healthcare reform to work with the Feds to keep mental health in the discussion and prevent our folks from becoming more invisible. DHCS is aware of these concerns. There are several proposals:
  - Create a new Department of Behavioral Health
  - Executive level Administrator parallel to DHCS Director to represent Behavioral Health
  - Other options are also being considered

What opportunities do you see as a result of the transition at the state level?

Consumers/Family Members/Consumer Advocates

- Find out what are other states doing regarding government reforms
  - It feels like health plans only want to do the minimum
  - ADP and Mental Health were pulled out to get more attention and that might get lost.
  - Opportunity to do more programs like CalMEND
  - Opportunity to have early intervention especially at schools
  - To create navigation systems for clients within systems
  - Opportunity to work together collaboratively
  - More local (unique services) control
  - Mental health has often been missed, an opportunity for advocacy is now possible
  - MHSA has resulted in funding cuts to local pre-existing programs
  - Individuals need to help make a difference – not just millionaires.
  - Data collection has been a large problem at DMH, making it hard to justify needed funding.

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County Representatives

- Strengthening local Departments through simplification of Administration systems – counties spend a lot of time explaining processes to our consumers.
- Health, Drug and Mental Health Medi-Cal alignment provides an opportunity to facilitate better integration [of services].
- Opportunity for aging clients whose primary diagnosis may change over time. There may be an opportunity to continue to provide mental health services for that client and bill Medi-Cal.
- Improve the continuum of care for people with Dual diagnoses
- Integration of services means more access, no wrong door.
- Within community health clinics, there is a concern about physical healthcare trumping everything. Is there a way to stage it so that specialty mental health services don't get lost?
- We can't really help people with transportation between PCP to MH; this transition may lessen silos.
- There are many circumstances in which Medi-Cal population is misaligned– confusion between payment with county of placement, county of residence, county of Medi-Cal responsibility- cross county services can be improved with Medi-Cal integration.
- There could be opportunities to streamline data collection and reporting requirements.
- Provider communication increased between primary care physicians and mental health clinicians.

Providers

- Simplification and reduction in redundancy
- Bottom up planning
    - More responsive planning
    - Counties are the experts
- Tighter link between community needs and county response may lead to more customized/ pilot programs/creative intervention programs/innovative programs
- There is concern about funding being combined with reduced allotments to the individual state agencies.
- Combined billing systems can result in faster return of funds.
- Same day billing issues
    - The billing system should not drive services
    - Don't make the client have to come back another day
    - There is an opportunity to consider a healthcare reform model that addresses this concern
- Opportunity within Medi-Cal Realignment:
- Aging clients and changing diagnosis can still be covered during these transitions
- In an integrated health system, need to make sure that people don't drop through the cracks.
- Having everything under one umbrella may help fill gaps in care (e.g., Alzheimer's treatment)

Phone Participants

- There is the possibility of more integration of mental and physical healthcare services.
- The process of drawing down MHSA funds could be streamlined and made less onerous.

Which entity should assume responsibility for the functions/programs listed? What functions/programs are missing from the list?

County Representatives

- What does financial oversight entail?
  - Federal funding released to counties
  - County plan review (i.e., PATH program)
  - MHSA funding distribution
- There should be an integrated reporting mechanism.
- Will this exercise inform what DMH will be in the future, assuming that DMH will be eliminated or morphed?
- To maintain "statewideness" there should be a single Behavioral Health entity.
- Statewide Prevention and Early Intervention projects should be kept together.
- Federal block grants stay together with all mental health program functions (maybe with Department of Healthcare Services and Medi-Cal programs)
- Unless CSI system will change, it makes sense to have counties report this data to one entity with a unified data set and one way of reporting.
- Wherever this information lives (data) there has to be a uniform/shared system so that everyone (all State entities) can have access to this information merged reporting system.
- It is important to create opportunities for counties to extract and utilize data.
- The State should build opportunities to have housing funding blended or merged to have a bigger pot of available funds for housing programs.
- Training and technical assistance could go to CalMHSA; especially if CalMHSA grows as an entity and assumes a larger role/responsibility.
- One reporting system would better support healthcare integration.
- The most important thing is shared responsibility/partnership with local level.
- The majority of counties have joined CalMHSA. They [CalMHSA] are the statewide representative of counties.

Providers

- Are there diverse members on the CA Mental Health Planning Council? Is there Native American representation?
- Is DHCS expanding rapidly?
- Does CalMHSA provide services or do they just do policy work?
- Do we know what financial support is allocated for each function?

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- There needs to be oversight to ensure fairness across the lifespan.
- Are we [the state] dispersing funding fairly? Historically, we have seen an imbalance.
- Where at the state level is there oversight for MHSA?
- Will future funding be guaranteed?
- We need local authority for financial oversight. However, there is a risk of corruption and lack of oversight.
- The fairness vs. efficiencies issues is long standing.
- The state took a long time to review plans and money took a long time to get to counties.
- How will (non DHCS/Medi-Cal) audit/compliance issues change?
- Will EQRO continue? Does DHCS have an outside/external reviewer?
- Data Collection function:
- Will DMH analyze county data? Who will analyze the data?
- [Data analysis] needs to go statewide, similar to how the MHSOAC does statewide evaluation with UCLA.
- What are the stakes involved with data collection?
- If you don't report the Medi-Cal data, you don't get money.
- We should have one centralized location to report data so counties do less work and spend less time on reporting.
- Reduce the duplicated requirements due to different funding streams with different funding requirements.
- Think about performance outcome measures.
- Hold a stakeholder meeting to discuss how we should move forward with these functions.
- Housing should be at the local level.
- Suicide Prevention: Keep partnerships with DMH and CalMHSA (CalMHSA voting is weighted for large counties per population size).
- Caregiver Resource Centers:
    - Regulation consistency is critical
    - The funding should not go to the Department of Aging, but it needs state oversight.
    - DHCS would be a good option for oversight during healthcare reform transition.
- Multicultural Services:
    - Need state level oversight: keep the Office of Multicultural Services at DMH
    - Make sure the folks reviewing the Cultural Competence Plans are diverse and representative of the lifespan
- Veterans Mental Health: What supports does this have at DMH? Keep it at DMH because there are not enough resources.
- Suicide data omitted the highest % of suicide – aging population. We need to be at the table, let's not perpetuate the disparities.
- WET:
    - DMH isn't approving but keeps funding/stipends/statewide student stipends/etc.
    - CiMH did many WET webinars
    - WET left out the Aging population, this was a missed opportunity.

Phone Participants

- Stakeholders are being asked to decide where functions should reside, but in many cases, do not have sufficient background and knowledge of the current functions to make this

decision. There are varying degrees of stakeholder knowledge and it is challenging to make a recommendation on the topic without adequate information.
- It would be helpful for the CA Department of Mental Health to identify what it believes to be essential functions to remain and the state level and which functions would not make sense at the local level.

Break-Out Themes

- Healthcare reform
- Continued focus on alcohol and drug services and mental health within new structure
- Stigma reduction and early intervention
- System navigators
- Integrated funding and billing
- Local control
- More collaboration with local stakeholders
- Data collection and reporting redundancy reduction
- More innovative/creative programs
- Same-day service option
- Simplification of Administrative function leads to efficiency
- Provider coordination: shared information, communication, improved continuum of care

What do you believe are the challenges associated with the changes to mental health at the state level? How can these challenges be addressed?

- Cross-cultural communication between state entities is a way to meet some of these challenges
- Continued stakeholder input
- Take time to learn about Mental Health, AOD, DHCS
- County communication/"cross-pollination"
- Clients worried about loss of benefits – they need reassurance to understand that resources/services will continue to be provided and this change not about benefits.
- Create a process on how to mitigate these challenges and include: clients, family, community, state, and local level entities.
- Establish a concrete problem-solving process
- There are too many unknowns regarding lack of budget/resources.
- Funds used for intended purpose
- Equality of opportunity and fairness
- Limited role of oversight (MHSOAC), there is a need to expand oversight have an entity to assume this function
- Not a good understanding of functions or roles of different state agencies
- What do counties do about guidance (i.e., existing regulation, policy, etc.)?
- Rule-making at state level lost, there are 58 different counties and they need clear guidance.
- Close attention should be paid to how local mental health programs are provided with information and communication. Lack of information and technical assistance inhibits

counties ability to communicate. Some entities are new players to specialty mental health which will require these entities to learn and be open to county feedback/communication
- Keeping a recovery focus may be difficult as we move to DHCS. DHCS' knowledge and support of recovery principles is of great concern with local stakeholders.
- Healthcare is historically cost-focused not wellness focused.
- Prevention and Early Intervention funding is a state level funding source – we should not lose PEI focus.
- This could just lead to more entities to report to and more reporting requirements for counties.
- Stakeholders have limited background or knowledge about state level functions. What does DMH think are "essential" functions to remain at State level?

Phone Participants

- With Medi-Cal mental health functions transferring to DHCS, will there be staff with the mental health background and knowledge to perform these functions?
- Much progress has been made towards the "recovery model" and using recovery oriented language in the Medi-Cal system, but with functions transferring to DHCS, will this progress be lost? Will the recovery model be pushed back into a medical model?
- Oversight of MHSA funds needs to remain at the state level to ensure that counties are using the funds appropriately. This state oversight should focus less on paperwork and administration and more on quality and outcomes.
- Although there are general Medi-Cal rules and regulations on a statewide level, every county interprets them differently and has their own way of implementation (i.e. billing codes, client plans). Changes at the state level could lead to more variance across counties **or** it could be an opportunity to bring more cohesion and a standard way of interpreting rules and regulations across the state, which would be a benefit to clients and families.

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